

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Eddy Village Green		STREET ADDRESS, CITY, STATE, ZIP CODE 421 W Columbia Street Cohoes, NY 12047	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during an abbreviated survey (NY00373673), the facility did not ensure the environment remained as free of accident hazards as possible for 1 (Resident #1) of 1 resident reviewed for accident hazards. Specifically, for Resident #1 the facility did not ensure the resident's bed was positioned away from the heating unit resulting in a second degree burn to the resident's arm.</p> <p>This is evidenced by:</p> <p>Resident #1 was admitted to the facility with diagnoses of Alzheimer's Disease (a degenerative neurological disease-causing memory loss), peripheral vascular disease (disorder of the blood vessels), and psychotic disorder with delusions (mental health condition in which a person can't tell what's real from what's imagined). The Minimum Data Set, dated [DATE] documented the resident could usually understand, could be understood, and was severely cognitively impaired.</p> <p>The Care Plan dated 2/15/2024 and titled, Safety awareness deficit related to confusion/decreased memory, decreased strength/endurance, Dementia, history of falls, Impulsive behaviors, Limited mobility, documented the bed was to be positioned against the wall on the left side near the window.</p> <p>In a written statement Licensed Practical Nurse #1 documented they entered the resident's room on 3/02/2025 at 9:45PM to find the resident lying in bed sideways with left arm and shoulder on heater. The resident's left arm had burn marks and was hot to touch.</p> <p>A Hospital Discharge summary dated [DATE] documented the resident presented with first and second degree burns of the left lateral humeral area from contact with a heater. Patient denied pain and declined pain medication. Antibiotic ointment and dressing applied. No additional care is needed for the burn.</p> <p>During an observation on 3/06/2025 at 11:20AM, all beds in House 12 were observed to be positioned away from the heat source. Resident #1 was in bed, lying sideways with one foot on the floor.</p> <p>During an interview on 3/6/2025 at 11:30AM Certified Nurse Aide #2 stated they were not here at the time of the incident but was told about it and told to make sure all beds are always away from the heaters. Reports resident moves around in bed a lot and likes to have one foot on the floor most of the time.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Eddy Village Green		STREET ADDRESS, CITY, STATE, ZIP CODE 421 W Columbia Street Cohoes, NY 12047	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/6/2025 at 11:45 AM Certified Nurse Aide #3 stated they were aware of incident and were told to keep beds away from heaters. Has never noticed any of the heaters feeling too hot and not aware of any other incidents like this.</p> <p>During an interview on 3/6/2025 at 11:35AM Resident #1 stated they were comfortable in the bed and feeling good. Resident was asked about the incident and stated they were fine, nothing happened.</p> <p>During an interview on 3/6/2025 at 2:30PM Senior Maintenance Manager #1 stated a heating company came in to check all heating units and found a faulty valve in Resident #1's heater and two others in the facility. The valves were replaced.</p> <p>During an interview on 3/6/2025 at 2:30PM Maintenance Manager #1 checked the temperature all heating units in the facility, and all were at or below 160 degrees as they should be. They are looking into whether this is a safe temperature and if it can be adjusted and still maintain comfortable room temperatures.</p> <p>Past Non-compliance -F689</p> <p>Based on the following corrective action taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of this survey.</p> <p>-</p> <p>Appropriate first aid and medical care were provided to the resident.</p> <p>-</p> <p>The incident was reported appropriately to the State Survey Agency</p> <p>-</p> <p>A thorough investigation was completed.</p> <p>-</p> <p>Education was provided to all staff regarding following positioning beds near heat sources.</p> <p>-</p> <p>The resident's Care Plans were updated to reflect the proper bed position.</p> <p>-</p> <p>An outside vendor was brought in to inspect all heat sources in the facility for malfunctioning and correct identified issues.</p> <p>-</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Eddy Village Green		STREET ADDRESS, CITY, STATE, ZIP CODE 421 W Columbia Street Cohoes, NY 12047	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Maintenance staff have checked all heat source temperatures and will continue to audit to maintain safety.</p> <p>At the time of survey, there were no additional injuries identified as resulting from beds being placed near heat source.</p> <p>10 New York Code Rules and Regulations 415.12(h)(1)</p>		